

# Mixing politics and prescriptions



*Last May, Maine became the first state to pass a law allowing it to enact price controls on prescription drugs if manufacturers do not significantly lower them by 2003. Although the law has been challenged in court, officials in at least 20 other states have said they are considering similar legislation. Here's an overview of the issue, and what the states are doing about it.*

**BY CATHERINE COWAN**

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One of the most talked-about issues during the last election cycle was the price of prescription drugs. News reports featured senior citizens who had to choose between food, heat or prescription drugs, who cut their pills in half to make prescriptions last longer, or who couldn't afford to get prescriptions filled.

Such anecdotes are not the only evidence that seniors need help with the cost of prescription drugs. Consider these statistics:

- Between 1995 and 1999, the amount Americans spent on prescription drugs more than doubled from \$65 billion to \$125 billion per year.
- In 1999, the amount of money spent on prescription drugs increased by a record 17.4 percent, even as all health spending increased by only 5.3 percent, according to a study by Express Scripts of St. Louis, a health-care management group. Americans spent an average of \$387.09 each on prescription drugs in 1999, the study said.
- Experts predict that the amount Americans spend on prescription drugs will continue to in-

crease by 15 percent to 18 percent per year. One government study projects that spending on prescription drugs will reach \$243 billion by 2008.

Senior citizens are especially affected by the rising expenditures on prescription drugs. Because drugs are available for more conditions than ever before, an elderly person today takes an average of 29 prescriptions a year, compared with 20 in 1992, according to a study by Families USA, a health-care advocacy group. The study found that the average price of a prescription also has risen from \$28.50 in 1992 to \$42.30 in 2000. As a result, Americans ages 65 and older paid an average of \$1,205 each in 1999 for prescription drugs — up from \$559 each in 1992 — and they are projected to pay an average of \$2,810 each by 2010.

### Little federal help

Unfortunately, the federal government so far has done little to address the issue. Medicaid, the joint federal-state program that provides health care for the country's very poorest people, has a prescription-drug benefit. But Medicare, begun in 1965 to pay for the health care of the nation's disabled and senior citizens, covers the cost of prescription drugs only when someone is in the hospital. At the time the program began, this made sense because hospitalization was usually the first course of action when someone got sick. Now, however, doctors are much more likely to treat the person as an outpatient with prescription drugs. Although this approach saves health-care costs overall, some Medicare beneficiaries have trouble paying for these drugs. About two-thirds of the nation's 40 million Medicare beneficiaries have

some type of prescription-drug benefit through such programs as retiree health insurance or purchased Medigap policies; however, many are seeing these benefits scaled back or even eliminated. Then there are the 13 million people on Medicare who have no prescription-drug benefit whatsoever.

Politicians on the national level have debated overhauling Medicare to add a prescription-drug benefit since at least June 1999, when President Clinton proposed the idea. Yet Congress could not agree on a plan and little was done. The only measure Congress did pass — as part of a broad \$78



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million spending measure for the Department of Agriculture — was a “reimportation bill.” The bill allows pharmacies to reimport drugs that U.S. companies have sold to other countries under price controls and sell them here at a discount. However, the measure has many legal, financial and logistical problems. Many drugs are sold under a different name and in a different form in the United States than in other countries; for example, Prilosec is sold in Canada as Losec, and comes as a white tablet instead of a purple pill. Most reimported drugs would have to be repackaged and relabeled to conform with U.S. regulations. The bill

allocated \$23 million to the Food and Drug Administration to deal with these problems, but that money runs out after one year.

Meanwhile, many people have found another solution. Every day, Americans head to Canada or Mexico to buy prescription drugs. The drugs are cheaper across the border because Canada and Mexico impose price controls, while the United States is the only industrialized country that does not. A 1998 study prepared for U.S. Rep. Thomas Allen of Maine by the Committee on Government Reform and Oversight found that the 10 brand-name prescription drugs with the highest dollar sales to the elderly cost an average of 72 percent more in Maine than in Canada, and 102 percent more in Maine than in Mexico. Some examples: 60 tablets (5mg) of Zocor cost \$103.92 in Maine, but \$43.97 in Canada and \$47.29 in Mexico; 30 caplets (20mg) of Prilosec cost \$111.89 in Maine, but \$53.51 in Canada and \$29.46 in Mexico; and 100 tablets (50mg) of Zoloft cost \$213.28 in Maine, but \$124.41 in Canada and \$155.52 in Mexico. These price differences did not escape the notice of candidates in at least 11 states who chartered buses to take people to Canada and Mexico to buy prescription drugs.

In the absence of federal action to help seniors pay for prescription drugs, states have been stepping in. Although states have enacted a wide variety of measures, the programs break down into three basic types: state as subsidizer, state as purchaser and state as regulator.

### State as subsidizer

Under this model, the state pays some or all of the cost of prescription drugs, usually for low-income seniors and people with disabilities who do not qualify for Medicaid. Most of these programs, often referred to as pharmaceutical assistance programs, require beneficiaries to meet certain income, age and disability limits. For example,

the largest program, Pennsylvania's Pharmaceutical Assistance for the Elderly, or PACE, which serves 217,103 people, covers single people over 65 who earn to \$14,000 per year and married people over 65 who make up to \$17,200 per year. The state's PACE-NET, or Needs Enhancement Tier, extends the income limits to \$16,000 for single people 65 and older and \$19,200 for married people 65 and older, serving an additional 18,655 people.

Most pharmaceutical assistance programs require beneficiaries to share the cost of prescription drugs through features such as annual enrollment fees, copayments or deductibles. Pharmaceutical assistance programs have been adopted in 22 states and are currently active in 16. Nine states have funded their programs at least in part from money gained through their settlement with the tobacco companies.

### State as purchaser

Under these programs, the state, either directly or through a pharmacy benefits manager, uses its power to purchase prescription drugs in bulk for groups such as prison inmates, hospital patients and Medicaid recipients to obtain price breaks for other groups such as seniors, people with disabilities, state employees and the uninsured. Two states, Maine and Massachusetts, have passed laws authorizing bulk-purchasing programs. Negotiations with manufacturers may involve "formularies," in which a state agrees to buy certain drugs in bulk in exchange for lower prices. And negotiations may be voluntary or mandatory. Under Maine's Rx Program, if a drug company refuses to negotiate a bulk-purchasing agreement with the state, its drugs will be put on a prior authorization list, meaning that they will not be covered unless a doctor convinces the state Department of Human Services that they are medically necessary.

### State as regulator

So far, Maine is the only state to attempt to regulate the price of prescription drugs. Under its Rx Program, if bulk-purchasing negotiations fail to significantly lower the price of prescription drugs by 2003, the human services commissioner will set the maximum prices that manufacturers may charge in the state. To avoid price controls, manufacturers must sell



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drugs to the state at prices equal to or less than those they charge to preferred customers such as large insurance companies, HMOs and the federal government. Such price differentials can be quite large. Another 1998 study prepared for U.S. Rep. Thomas Allen of Maine by the Committee on Government Reform and Oversight found that the average retail price for the 10 brand-name prescription drugs with the highest dollar sales to the elderly was 86 percent higher than the average price charged to the federal government. As a final inducement to persuade drug manufacturers to lower prices, the Maine Rx Program also allows the state to sue a drug company for profiteering if it believes the com-

pany is charging unconscionable prices for or restricting the sale of prescription drugs.

Neither Maine's nor Massachusetts' programs have officially begun. In Massachusetts, officials are still working on an implementation plan for its bulk-purchasing program. And in Maine on Aug. 11, the day before the Rx Program was to have become effective, the Pharmaceutical Research and

Manufacturers of America, or PhRMA, sued in federal court to block its implementation. Before that lawsuit was heard, U.S. District Judge D. Brock Hornby issued a preliminary injunction barring Maine from implementing any part of the program that penalizes drug manufacturers, such as putting their drugs on a prior authorization list or suing them for profiteering. Maine Attorney General Andrew Ketterer has appealed Hornby's injunction. Meanwhile, Maine officials have said they plan to go ahead with the parts of the program that the injunction does not stop, namely the voluntary bulk-purchasing agreements the state had made as of late November with more than 60 drug companies.

### Reaction and debate

While drug manufacturers generally support pharmaceutical assistance programs in which the state acts as subsidizer, they oppose price controls, or states as regulators. How drug manufacturers feel about bulk-purchasing programs — or the state as purchaser — depends on how the program is administered, said Chris Badgley, vice president of state government affairs for PhRMA. If the state uses a private pharmacy benefits manager to negotiate bulk-purchasing agreements on the free market, and if manufacturers can

enter into such agreements voluntarily, drug companies will not have a problem, Badgley said. But if, as in Maine, the state ties its role as purchaser to its role as regulator through mandatory bulk-purchasing agreements and price controls, drug companies will oppose it, he said.

PhRMA's lawsuit argues that the Maine Rx Program violates the U.S. Constitution in two areas: the Supremacy Clause, which prohibits states from passing laws that conflict with federal laws, and the Interstate Commerce Clause, which prohibits states from passing laws that regulate commerce outside their borders. Maine's Rx Program violates the Supremacy Clause, PhRMA says, because it threatens to put the products of drug manufacturers who refuse to enter into bulk-purchas-

ing agreements on a prior authorization list for Medicaid. In other words, Maine is attempting to force manufacturers to participate in a state program by threatening to curtail access to its drugs through a federal program. Maine's Rx Program also violates the Interstate Commerce Clause, PhRMA says, because it seeks to control the price at which manufacturers can sell their products to wholesalers, a transaction that usually takes place outside its borders. In issuing his preliminary injunction against the program, Judge Hornby wrote that while Maine has a strong interest in assisting its economically and medically needy citizens, "I find the plaintiff's likelihood of success on the merits of most of its constitutional challenges to be overwhelming."

Besides being unconstitutional, drug

manufacturers argue, the Maine Rx Program is simply bad medicine. If states cut drugmakers' profits through mandatory bulk-purchasing agreements and price controls, PhRMA says, research on new drugs will suffer. According to PhRMA, it costs \$500 million and takes 12 to 15 years to develop one new drug, and only one in 10 drugs developed ever makes it onto the market. Even then, only three of 10 drugs turn a profit, meaning that pharmaceutical companies must rely on just a few high-profile drugs to make the money they need to fuel their research. Furthermore, PhRMA says, the pharmaceutical industry invests more of its profit — \$26.4 billion in 2000 — into research and development than does any other industry. As a

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## More ways to reduce costs

Besides assuming the roles of subsidizer, purchaser or regulator, states have taken two other approaches to helping their residents pay for prescription drugs. The first is to expand the reach of Medicaid, which has a prescription-drug benefit, to give the same price to people on Medicare, which does not. Depending on how this is done, the state, pharmacists or manufacturers can pay the difference. For example, in Florida the state has set aside more than \$15 million to give Medicare beneficiaries the Medicaid prices on prescription drugs. In California, pharmacists are required to give the same price on prescription drugs to Medicare beneficiaries as they give to Medicaid beneficiaries. And in Vermont, a law passed in May and approved by the federal Health Care Financing Administration in November seeks to extend Medicaid drug prices to low-income seniors. The law allows seniors whose annual income is over 175 percent of the federal poverty level and others whose annual income is under 300 percent to receive the same rebate from prescription-drug manufacturers that Medicaid beneficiaries get. PhRMA filed suit in federal court in December to block the program.

The other approach states have taken to helping residents pay for prescription drugs has been to create buyers' clubs. This has been done by executive order in three states — Iowa, New Hampshire and Washington. For example, Washington Gov. Gary Locke established A Washington Alliance to Reduce Prescription-Drug Spending, or

AWARDS, to begin in January 2001. Under the program, residents ages 55 and older will pay \$15 per year for individuals and \$25 per year for families to receive discounts of 12 to 30 percent when they buy prescription drugs at participating pharmacies and 20 to 49 percent when they order from participating mail services. Such discounts are possible because the state will piggyback these purchases onto its Uniform Medical Plan, which buys prescription drugs in bulk at significantly lower prices.

Besides tackling the cost of prescription drugs individually, three states — Maine, New Hampshire and Vermont — also have banded together to tackle the problem collectively. On Oct. 24, Maine Gov. Angus King, New Hampshire Gov. Jeanne Shaheen and Vermont Gov. Howard Dean announced that they were forming a three-state buying pool for prescription drugs. Although the pool still must get approval from the federal government, the governors also issued a request for proposals from pharmacy benefits managers to negotiate with drug manufacturers on their behalf. The governors plan to review the bids in January, choose a pharmacy benefits manager in the spring, and launch the program by the summer. Although at first the program would buy drugs just for the states' Medicaid patients, the governors hope to expand the program to cover state employees, low-income seniors and the uninsured — up to 1 million people. The ultimate goal is to cut the amount that beneficiaries now pay for prescription drugs by up to 35 percent. — CC

lions of dollars to citizens, and yet unclaimed property programs are under assault by holders of unclaimed property who resist state efforts to reunite property with owners.”

Virginia’s unclaimed property statutes recently faced challenges by a coalition of holders resulting in significant revisions to its unclaimed property law. During the 1999 General Assembly session, concessions to the holder community included elimination of gift certificates and credit balances as property items that holders must escheat to the state. At the same time the Legislature expanded penalties for non-compliance to enhance state collection efforts. “There needs to be a balance between the interest of the holder community and the consumer,” said Vir-

ginia Treasurer Mary Morris. “Unclaimed property statutes have been under attack for a number of years,



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and state unclaimed property divisions have attempted to maintain the integrity of their statutes. They want to fulfill the purpose of protecting individual citizens in reuniting them with their funds or property,

while at the same addressing the legitimate concerns of the holder community. This is not always an easy process for either side.”

Recently, two powerful public-service organizations joined forces to

preserve these state laws protecting unclaimed property. The National Association of State Treasurers and the National Association of Unclaimed Property Administrators affiliated, bringing together state policy-makers and program administrators. Both also are affiliated with The Council of State Governments. This new coalition will pool resources to further protect the rights of citizens.

Stephen E. Larson, NAUPA president and executive officer of the Iowa Treasury Department, lauded the alliance, saying, “States have faced challenges and have tried to reconcile the two interests. We’ve made concessions, but also amended the penalties to allow us to do our jobs more efficiently.” ★

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result, the United States developed almost half of the world’s drugs from 1975 to 1994, and 370 new medicines in the last decade alone. By cutting into profits, PhRMA says, mandatory bulk-purchasing agreements and price controls would chill investment in pharmaceutical companies, thus slowing research.

On the other side, lawmakers in states such as Maine say they cannot afford to continue paying more for prescription drugs. Former state Senate Majority Leader Chellie Pingree, the Democrat who led the effort to pass the Rx Program, said Maine pays such increased costs in two ways. First, the state pays for drugs through its pharmaceutical assistance program, the Low Cost Drugs for the Elderly Program, established in 1975. Second, when Maine residents who can’t afford to buy prescription drugs end up in a hospital or nursing home, the state must foot the bill. The solution, said Pingree, is to try to get drugmakers to lower their prices.

“If they can make these prices avail-

able to HMOs and citizens in Canada, why can’t we receive the same prices for our senior citizens?” she asked.

Pingree argued that bulk-purchasing agreements are common in the private sector. “That’s exactly how an HMO formulary works,” she said. “The process allows us to favor particular companies that have lower-priced drugs.”

Prior authorization lists also are used often, Pingree said. “We are trying to use a private-sector solution,” she said. “Yet it’s the private sector that is not covering our senior citizens.” And Pingree pointed out that the preliminary injunction does not stop the state from publicizing which companies won’t agree to negotiate. “Doctors and patients have sent letters to them, so they are still being pressured,” she said.

Maine residents think the Rx Program is an excellent prescription for their state, Pingree said. “When we first put the idea out there for debate, citizens were strongly supportive,” she said. “They were out there saying, ‘This is a serious issue, we can’t afford

to pay for prescription drugs,’ and doctors were out there saying, ‘We are writing prescriptions but patients aren’t getting them filled.’ There was a huge response.” The state Senate passed the program unanimously, 141 of 151 members of the House voted for it, and Gov. Angus King, who had toyed with the idea of vetoing it, has become one of its biggest boosters.

Interest in the program outside of Maine also has been high. Pingree said that from June to November, she has testified in, received calls from and sent copies of legislation to officials in at least 25 states. Pingree agrees with drug manufacturers that profits are at the center of the debate. “It’s all about money, no question about it,” she said. “States are big customers. Drug companies have seen what has happened in Maine and they are afraid it could spread to other states.”

As legislative sessions meet, just how many states decide to take Maine’s approach may hinge on the courts and their willingness to step into the unfamiliar territory of price controls. ★